MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DEEPAK V. CHAVDA, MD, PA

MFDR Tracking Number

M4-15-0177-01

MFDR Date Received

SEPTEMBER 15. 2014

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE CO

Carrier's Austin Representative

Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services were denied in error stating CPT code 29876 does not support level of service billed. I now call your attention to the Operative Report that fully explains in detail, step by step in the description of procedure. Note the compartment of the procedure where the loose body was removed from. The loose body was removed from the patellofemoral compartment. As long as the procedures are performed in the different compartment which they are, they are reimbursable. Your denial calls attention to NCCI edits. Please look at my claim and notice the -59 modifier to indicate distinct procedural service. As you know, NCCI will allow the modifier. Please review the4 attached documentation supporting that these CPT codes are separately reimbursable per NCCI. In addition, CPT 20610 was denied as included as well. Please review the last paragraph where the doctor wanted to bring additional comfort to the corrected area, the knee had to be injected with steroid and local anesthetic agent. Again, the -59 modifier is on this and needs to be considered separate."

Amount in Dispute: \$3,764.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed CPT of 29876 flags a NCCI Edit when billed with CPT 29888 and 29880. The operative record shows that CPT 29876-59 was performed in the patellofemoral joint, and in the lateral and medial compartments. CPT 29876-59 as billed is not supported in the documentation because the synovectomy was performed in the same compartments as the meniscectomy (medial and lateral) and same site as the ACE; therefore Modifier 59 is not supported. CPT 20610 flags a NCCI Edit when billed with CPT 29880, 29876, and 29888. The operative record shows that a steroid anesthetic injection was given through the medial portal. CPT 20610-59 as billed is not supported in the documentation because the injection is given through the same medial portal as the procedures performed during the same operative session. Modifier 59 is therefore not supported."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2014	CPT Code 29876-59-LT Knee Arthroscopy	\$3,461.79	\$0.00
	CPT Code 20610-59-LT	\$303.00	\$0.00
Total		\$3,764.79	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- 3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
 - X901-Documentation does not support level of service billed.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

- 1. Does the documentation support billing CPT code 29876-59-LT? Is the requestor entitled to reimbursement?
- 2. Does the documentation support billing CPT code 20610-59-LT? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for code 29876-59-LT based upon the service was not documented. The respondent contends that payment is not due because "The billed CPT of 29876 flags a NCCI Edit when billed with CPT 29888 and 29880. The operative record shows that CPT 29876-59 was performed in the patellofemoral joint, and in the lateral and medial compartments. CPT 29876-59 as billed is not supported in the documentation because the synovectomy was performed in the same compartments as the meniscectomy (medial and lateral) and same site as the ACE; therefore Modifier 59 is not supported."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

On the disputed date of service the requestor billed CPT codes 29888-LT, 29880-59-LT, 29876-59-LT and 20610-59-LT.

- CPT code 29888 is defined as "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction."
- CPT code 29880 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed."
- CPT code 29876 is defined as "Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)."
- CPT code 20610 is defined as "Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)."

The requestor appended modifiers "LT-left side" and "59-Distinct Procedural Service to code 29876.

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, CPT code 29876 is a component of code 29888 and 29880; however, a modifier is allowed to differentiate the service.

The requestor appended modifier 59-Distinct Procedural Service" to code 29876 to differentiate it from 29888 and 29880. Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported

together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The Operative Report indicates "OPERATIONS PERFORMED: 1. Left knee arthroscopy, examination under anesthesia, repair of the anterior cruciate ligament, 29888-LT. 2. Partial meniscectomy, medial and lateral, 29880-LT. 3. Tricompartmental chondroplasty, 29877-LT. 4. Tricompartmental synovectomy and loose body removal, 29876-LT. 5. Intraarticular injection, 20610-LT." The requestor documented that code 29876 was performed in all three compartments of the knee. Code 29880 was performed in two compartments. Based upon the code description for code 29876 the procedure has to be performed on 2 or more compartments to be billed. Because code 29880 was performed in the same compartments as 29876, the documentation does not support billing code 29876 with modifier 59. As a result, reimbursement is not recommended.

The respondent also denied reimbursement for code 20610-59-LT based upon the service was not documented.

Per CCI edits, code 20610 is a component of codes 29876, 29880, and 29888; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 20610 to differentiate it from 29888, 29880, and 29876.

A review of the submitted operative report does not support a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The Division finds that the requestor has not supported the use of modifier "59." As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		02/20/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 Texas Register 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the** *Medical Fee* **Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.